STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155159	A. BUILDING 01 B. WING	02/21/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUMMIT CITY NURSING AND REHABILITATION	2940 N CLINTON ST FORT WAYNE, IN 46805

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K0000	A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.70(a). Survey Date: 02/21/12 Facility Number: 000079 Provider Number: 155159 AIM Number: 100266160 Surveyor: Amy Kelley, Life Safety Code Specialist At this Life Safety Code survey, Summit City Nursing and Rehabilitation was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.70(a), Life Safety from Fire and the 2000 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2. This two story facility with a basement was determined to be of	K0000	The creation and submission of this Plan Of Correction does not constitued anadmission by this provider of any conclusion set forth in the statement of deficiencies, or of any violation of regulation. This provider respectfully requests that the 2567 Plan Of Correction be considered the letter of credible allegation and request a post survey review on or after March 22, 2012.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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	Type II (111) construction and was fully sprinklered. The facility has a fire alarm system with smoke detection in the corridor, areas open to the corridor and battery operated smoke detectors in the resident rooms. The facility has a capacity of 88 and had a census of 47 at the time of this survey. Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 02/27/12. The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:			

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K0018 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas are substantial doors, such as those constructed of 1¾ inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Doors in sprinklered buildings are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Doors are provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6.3.6 are permitted. 19.3.6.3 Roller latches are prohibited by CMS regulations in all health care facilities. Based on observation and interview, the facility failed to provide corridor doors to 1 of 1 kitchenettes and 1 of 1 sun porches. This deficient practice could affect any resident in the main dining room. Finding include: Based on observation with the Maintenance Director on 02/21/12 at 1:20 p.m., the main dining room had a sun porch and a kitchenette off either side of the room. These rooms lacked doors and were separated from the main dining room by arched door ways. The main dining room was not separated from the corridor. This	K0018	Automatic Supervised Smoke detectors will be installed in the Sun Porch and Kitchenette located just off the main dining room on the second floor. The installation will be performed by professionals and will meet the guidelines set forth within the Life Safety Code Standards.This corrective action will ensure that the Sun Porch and Kitchenette will remain in compliance with Life Safety Code Standards.	03/19/2012

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	was acknowledged by the Maintenance Supervisor at the time of observation. 3.1-19(b)			

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K0029 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1 Based on observation and interview, the facility failed to ensure the corridor door to 1 of 1 basement Housekeeping storage rooms and 1 of 1 resident rooms used for storage of combustibles, measuring over 50 square feet in size, were provided with a self closing device. This deficient practice was not in a resident care area but could affect any number of staff and 3 residents on A hall. Findings include: a. Based on observation with the Maintenance Supervisor on 02/21/12 at 2:10 p.m., the corridor door to the basement Housekeeping storage room with combustible storage such as cleaning chemicals, blankets and	K0029	Self closing device was installed on the Housekeeping Storage room and room 106 doors. This corrective action will ensure that the closing of these doors meets Life Safety Code standards.	02/29/2012

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	privacy curtains lacked a self closing device. The Housekeeping storage room measured twenty one feet by thirty four feet in size. Measurements were provided by the Maintenance Supervisor. b. Based on observation with the Maintenance Supervisor on 02/21/12 at 1:45 p.m., resident room 106 was being used to store combustibles such as at least thirty cardboard boxes of new furniture, and the door lacked a self closing device. The room measured eighteen feet by eleven feet. Measurements were provided by the Maintenance Supervisor. 3.1-19(b)			

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K0038 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1 Based on observation and interview, the facility failed to ensure the means of egress through 6 of 7 exits was readily accessible for residents without a clinical diagnosis requiring specialized security measures. LSC 19.2.2.2.4 requires doors within a required means of egress shall not be equipped with a latch or lock that requires the use of a tool or key from the egress side. Exception No. 1 requires door-locking arrangements without delayed egress shall be permitted in health care occupancies, or portions of health care occupancies, where the clinical needs of the residents require specialized security measures for their safety, provided staff can readily unlock such doors at all times. This deficient practice could affect any resident without a medical diagnoses requiring security measures exiting through all exit except the Auguste's Cottage.	K0038	The code for exit access is posted at doors for accessibility at all times. This corrective action will ensure the means of egress through exits is readily accessible for residents without a clinical diagnosis requiring specialized security measures as well as family members and visitors.	03/06/2012

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	Findings include: Based on observation on with the Maintenance Supervisor on 02/21/12 from 12:00 p.m. to 2:15 p.m., with the exception of the Auguste's Cottage exit, all other exit doors were magnetically locked and could be opened by entering a code, but the code was not posted. The Maintenance Supervisor acknowledged the code was not posted at this time. 3.1-19(b)			

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K0143 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Transferring of oxygen is: (a) separated from any portion of a facility wherein patients are housed, examined, or treated by a separation of a fire barrier of 1-hour fire-resistive construction; (b) in an area that is mechanically ventilated, sprinklered, and has ceramic or concrete flooring; and (c) in an area posted with signs indicating that transferring is occurring, and that smoking in the immediate area is not permitted in accordance with NFPA 99 and the Compressed Gas Association. 8.6.2.5.2 Based on observation and interview, the facility failed to ensure oxygen stored in 1 of 1 sprinklered oxygen storage/transfer locations was separated from any portion of a facility wherein residents are housed, examined, or treated by a separation of a fire barrier of 1 hour fire resistive construction where electrical fixtures were at least 5 feet above the floor. NFPA 99, 8-3.1.11.1 requires storage for nonflammable gases shall comply with 4-3.1.1.2. NFPA 99, 4-3.1.1.2(a)(4) requires electrical fixtures, switches and outlets in oxygen storage locations be installed in fixed locations not less	K0143	The Transferring of osygen room is being relocated to an area that meets the Life Safety Code Standards. This corrective action will ensure that oxygen transferring room will remain in compliance of Life Safety Code Standards.	03/16/2012

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	than 5 feet above the floor to avoid physical damage. This deficient practice could affect any residents near the oxygen transferring room in the event of an emergency. Findings include: Based on observation with the Maintenance Supervisor on 02/21/12 at 12:55 p.m., the oxygen transferring room had two large liquid oxygen storage tanks placed in the room with two electrical light switches on the wall less than five feet above the floor. Additionally, the Maintenance Supervisor was unable to confirm the metal door was a forty five minute fire door and the ceiling provided a one hour rating. 3.1-19(b)			

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K0147 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2 Based on observation and interview, the facility failed to ensure 2 of 2 flexible cords such as an extension cord were not used as a substitute for fixed wiring. LSC 9.1.2 requires electrical wiring and equipment to comply with NFPA 70, National Electrical Code, 1999 Edition. NFPA 70, Article 400-8 requires, unless specifically permitted, flexible cords and cables shall not be used as a substitute for fixed wiring of a structure. This deficient practice was not in a resident care area but could affect any number of staff. Findings include: Based on an observation with the Maintenance Supervisor on 02/21/12, two heavy duty extension cords were plugged in and providing power to a sump pump and a light in the basement maintenance shop. This was acknowledged by the Maintenance Supervisor at the time of	K0147	The proper wiring has been installed to the pump and lighting in the maintenance shop. This installation was completed by professionals that perform task according to the National Electrical Codes. This corrective action will ensure the electrical equipment remains within the Life Safety Code standards.	03/06/2012

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	observations. 3.1-19(b)			